

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29624

State File No. _____

FILED SEP 19 1955

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>5551</u>		Registrar's No. <u>78</u>	
1. PLACE OF DEATH a. COUNTY <u>Newell</u> b. CITY (If outside corporate limits, write RURAL and give township) <u>Koshkoning</u> c. LENGTH OF STAY (in this place) <u>4 mos</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kidney</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lance</u> c. CITY OR TOWN <u>Koshkoning</u> d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>Rt 10</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary Rosalia</u> b. (Middle) <u>Valmar</u> c. (Last) <u>Valmar</u> 4. DATE OF DEATH (Month) (Day) (Year) <u>9-6-55</u>				5. SEX <u>m</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u> 8. DATE OF BIRTH <u>5-10-1878</u> 9. AGE (In years last birthday) <u>77</u> 10. IF UNDER 1 YEAR Months <u>2</u> Days <u>26</u> 11. IF UNDER 10 HRS. Hours <u>0</u> Mins. <u>0</u>			
10a. USUAL OCCUPATION (True kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (City and State or Foreign Country) <u>Kear Co., Mo.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Mass Mallery</u> 13b. MOTHER'S MAIDEN NAME <u>Jurenda Brewster</u> 14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT'S SIGNATURE OR NAME <u>Mass Mallery Koshkoning Mo</u> ADDRESS <u>None</u>				18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* a. <u>HYPERTENSION, CHR. ARTERIAL-SEVERE</u> b. <u>ARTERIO SCLEROSIS, CHR. SEVERE</u> c. <u>Diffusely Neurologic Overload</u> d. <u>Sensitive Dress for Body</u> e. <u>Malnutrition & Cachexia</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		447X	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>2 Sept</u> , 19 <u>55</u> to <u>6 Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2 Sept</u> , 19 <u>55</u> , and that death occurred at <u>3:45</u> m., from the causes and on the date stated above.							
23. SIGNATURE <u>Robert Cook</u> (Degree or title) <u>MD</u> 23b. ADDRESS <u>West Plains, Mo</u> 23c. DATE SIGNED <u>SEP 10 1955</u>				24a. BURIAL, CREMATION, RESURVAL (Specify) <u>Burial</u> 24b. DATE <u>9-8-55</u> 24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u> 24d. LOCATION (City, town, or county) (State) <u>Kear Co. Mo</u>			
DATE REC'D BY LOCAL REG. <u>9-15-55</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Samuel</u> ADDRESS <u>None</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. D. Leavitt*

Licensed Embalmer No. *363*

P. O. Address *Leavitt*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.